UPDATE
DRUGS DON'T WORK IN NJ!
Partnership for a Drug-Free New Jersey
In Cooperation with the Governor's Council on Alcoholism & Drug Abuse and the New Jersey Department of Human Services
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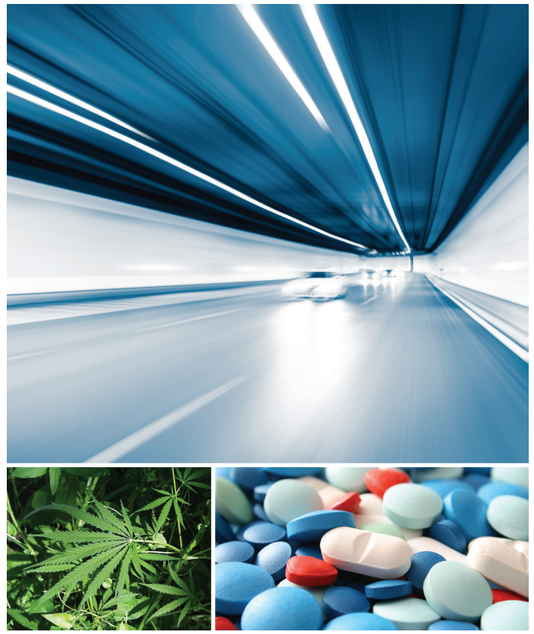
DUI: It's Not Just About Alcohol

By J Michael Walsh, PhD & Robert L. DuPont, MD

Driving is a complex task that requires continuous information processing and coordinated responses to ever-changing traffic while operating a multi-ton vehicle on public roads. Clearly, drugs that alter a driver's normal brain functioning can create an extremely hazardous situation. Drugged driving has become a national threat that rivals the dangers caused by the better-recognized problem of drunk driving. The massive national response to drunk driving - including more than 1.5 million arrests a year for DUI -has driven those numbers down over the past decade. But the nation's 16 million current users of illegal drugs have faced no similar effort as they continue to drive under the influence of drugs like marijuana, cocaine, methamphetamine, and opiates.

A number of surveys have shown that roughly 80% of drug users will drive a motor vehicle after having used illicit drugs. An analysis of the most recent U.S. National Survey on Drug Use and Health (2014) estimates that more than 10 million drivers in the United States drove under the influence of an illicit drug [DUID] during the previous year. The highest drugged-driving rates reported were among the young, least-experienced drivers [i.e., 18-25 years old].

In 2013-2014 the National Highway Traffic Safety Administration [NHTSA] conducted the most recent National Roadside Survey of Alcohol and Drug Use by Drivers. This survey is used by the Federal government to produce national estimates of the scope of the problem. Drivers in various locations around the country were randomly stopped and asked to voluntarily provide breath, blood and oral fluid specimens. The blood and oral fluid was tested for the presence of potentially impairing drugs. Drugs were more prevalent than alcohol among weekend nighttime drivers: 8.3% had some traces of alcohol, while 15.2% had some form of illegal drugs in their systems and 12.6% tested positive for THC, the psychoactive ingredient in marijuana [Berning, et. al, 2015].



Despite the mounting research evidence that driving under the influence of drugs (other than alcohol) is common, there is minimal public awareness of this fact, and drugged drivers are less frequently detected, prosecuted, or referred to treatment when compared to drunk drivers.

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Look Inside for Details

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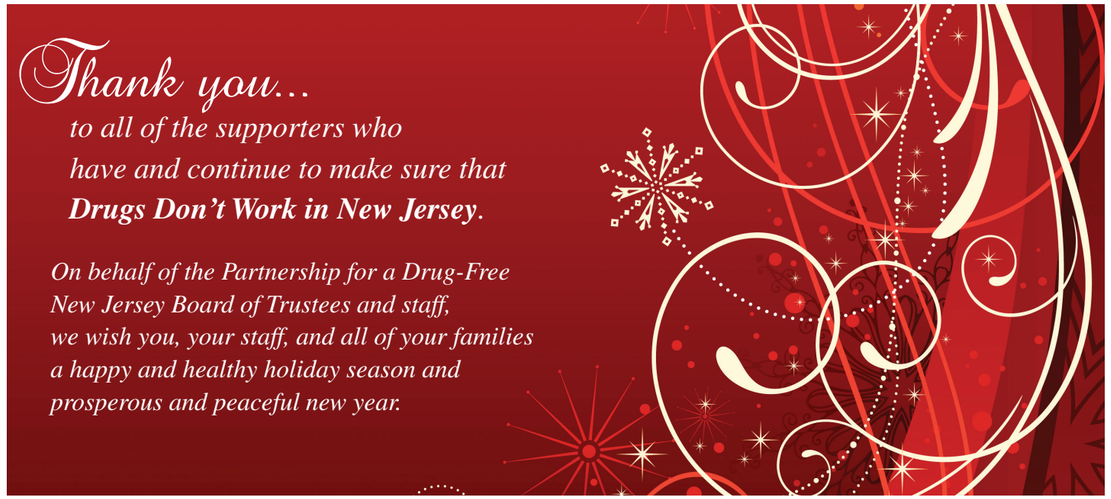

There are three principal types of drugged-driving laws:

1) Statutes that require drugs to render a driver "incapable" of driving safely;

2) Statutes requiring that the "drug impair the driver's ability to operate safely" or require a driver to be "under the influence or affected by an intoxicating drug"; and

3) "Per se" statutes that make it a criminal offense to have specific levels of a drug or metabolite in one's body/body fluids while operating a motor vehicle (prohibitions of any detectible amount are often referred to as "zero tolerance laws")

Historically, attempts to control drugged driving have relied on impaired driving laws that require the prosecution to demonstrate (1) impaired driving behavior, (2) the presence of a drug in the body, and (3) a connection between the drug and the impaired behavior. Because enforcement based on this complex approach is difficult, drugged driving is seldom identified or prosecuted in the United States.

Because of the relatively straightforward relationship between alcohol concentration in the blood and behavioral impairment, there is a strong basis for establishing BAC limits based on the extent of impairment or crash risk associated with a given BAC. The success of setting such limits for alcohol control laws and enforcement has encouraged the attempt to apply similar impairment requirements to DUID illegal per se laws. There is substantial doubt, however, that this can be done for more than a very few of the more than 100 substances that can impair driving behavior. In fact, even with alcohol, the 0.08 BAC limit used in the United States is a political determination rather than scientific proof of impairment. Some individuals' driving skills will be impaired at much lower levels of alcohol, while experienced long-term alcohol-tolerant drinkers may not be impaired at 0.08. However, US laws stipulate that 0.08 BAC is "per se" evidence of impairment. Countries like Sweden and Norway have set per se BAC limits at 0.02, and most European nations and Australia are at 0.05.

To deal more effectively with drugged driving in the United States, there has been increased interest in applying per se illegal laws to make it a crime for a person to operate a motor vehicle with a specified level of certain drugs in his or her body. Such laws are based primarily on chemical test results; however, they typically require evidence of driver impairment and reasonable suspicion of drug involvement to collect the specimen for testing.

Many state legislatures have added statutory language to their state codes proscribing operation of motor vehicles "under the influence'" or "while impaired" (or a variety of similar terms) by "illegal drugs," or impairing substances, often referencing the Federal controlled substances list, or specific drug classes (e.g., amphetamines, central nervous system depressants).

As a result of the overall prevalence of drug use in the United States, and the growing concern regarding the traffic safety implications of illegal drug use by drivers, over the last decade 17 states have taken the initiative to enact DUID per se laws: Arizona, Delaware, Georgia, Iowa, Illinois, Indiana, Michigan, Minnesota, North Carolina, Nevada, Ohio, Pennsylvania, Rhode Island, South Dakota, Utah, Virginia, and Wisconsin [see Walsh, 2009]. The majority of these state DUID statutes contain provisions for a substance abuse clinical evaluation, and education/treatment services for those convicted of drugged driving.

How does New Jersey's laws shape up with the rest of the Nation? The NJ code §39:4-50 prohibits a person to operate a motor vehicle while under the influence of a "narcotic, hallucinogenic or habit-producing drug".
However, there are several aspects of the current law that need revision to allow the intent of the law to be enforced and prosecuted. The list of prohibited drugs should be more specific, the statute does not extend the "implied consent' provision beyond breath testing, and it does not authorize the collection of any other specimen to be tested for drugs. These are serious flaws in the law, which essentially prohibit law enforcement officers from collecting the proof they need to prosecute a drugged-driving violation.

To complicate matters in the nation's drugged driving problem, an increasing number of states have legalized the "medical" use of marijuana for those age 18 and older and several states [Washington, Colorado, Oregon and the District of Columbia] have made "recreational" use legal for those age 21 and over. This growing phenomenon has traffic safety officials very worried.

NJ Addictions Hotline Dial 211

According to recent reports on the impact of marijuana legalization in Colorado [HIDTA, 2015], data show dramatic effects on traffic deaths:

- In 2014, when retail marijuana businesses began operating, there was a 32 percent increase in marijuana-related traffic deaths in just one year from 2013.
- Colorado marijuana-related traffic deaths increased 92 percent from 2010 – 2014. During the same time period all traffic deaths only increased 8 percent.
- Marijuana-related traffic deaths were approximately 20 percent of all traffic deaths in 2014 compared to half that (10 percent) just five years ago.

When individuals develop an addiction, there are often warning signs that provide opportunities to address the problem through early identification and treatment. Typical warning signs include trouble with the police (e.g., DUI, drunk and disorderly charges, drugged driving, etc.) or ending up in a hospital emergency room. These events can and should be used to identify substance use problems through evaluation and refer individuals to treatment. A more effective public policy to deal with the increasing problem of drugged drivers centers around the concept that detection and prosecution can not only improve traffic safety by creating a convincing deterrent, but it can also provide an opportunity for treatment for those drivers who violate the law.

New Jersey should invest in managing the drugged driving problem by increasing public awareness, by training a larger cadre of police officers to detect drugged drivers, and by sponsoring research to improve detection capabilities and better document the scope of the problem. The New Jersey legislature should be encouraged to reexamine their current drugged driving statutes and adopt zero tolerance per se laws that mandate arrest, evaluation and/or treatment for offenders. If some of those 16 million current illegal drug users can be taken off our roads, and encouraged to seek treatment, it will not only contribute to traffic safety, but also help to reduce drug use in the nation.

Crash Year	Total Statewide Fatalities	Fatalities with Operators Testing Positive for Marijuana	Percentage Total Fatalities (Marijuana)
2006	535	37	6.92%
2007	554	39	7.04%
2008	548	43	7.85%
2009	465	47	10.10%
2010	450	49	10.89%
2011	447	63	14.09%
2012	472	78	16.53%
2013	481	71	14.76%
2014	488	94	19.26%

*Fatalities Involving Operators Testing Positive for Marijuana
SOURCE: National Highway Transportation Safety Administration, Fatality Analysis Reporting System (FARS), 2006-2013 and CDOT/RMHIDTA 2014

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J. Michael Walsh, Ph.D. is the President of The Walsh Group, P.A. an applied research and consulting organization [HYPERLINK "http://www.walshgroup.org" www.walshgroup.org] established in 1993. He has been a member of the Scientific Advisory Group/ Steering Committee of the Partnership for a Drug Free New Jersey for more than 20 years. Dr. Walsh is an internationally known expert in substance abuse issues having served more than 28 years in Federal service in senior research and policy positions including serving at the White House as the Executive Director of the President's Drug Advisory Council [1989-93], Associate Director of the Office of National Drug Control Policy (ONDCP), and as the Director of Applied Research at the National Institute on Drug Abuse.

Robert L. DuPont, M.D. has been a leader in drug abuse prevention and treatment for over 40 years. He was the first Director of the National Institute on Drug Abuse (1973-1978) and the second White House Drug Chief (1973-1977). From 1968-1970 he was Director of Community Services for the District of Columbia Department of Corrections. From 1970-1973, he served as Administrator of the District of Columbia Narcotics Treatment Administration. In 1978 he became the founding President of the Institute for Behavior and Health, Inc., a non-profit organization that identifies and promotes new ideas to reduce illegal drug use. He has been Clinical Professor of Psychiatry at the Georgetown University School of Medicine since 1980. He is Vice President of Bensinger, DuPont and Associates, a national consulting firm dealing with substance abuse.

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